

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03199

3213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BARNITTE Middle ASHLEY Last ASHLEY				4. DATE OF DEATH Month March Day 22 Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October, 9, 1958	
9. AGE (In years last birthday) 5 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY Baby		11. BIRTHPLACE (State or foreign country) Wilmington, Del.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Ashley				14. MOTHER'S MAIDEN NAME Rosie Sudler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT James Ashley, Address Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous Bronchitis 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause fast. (b) Common cold DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 weeks 4 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 13, 1959 to February 19, 1959 , that I last saw the deceased alive on March 19, 1959 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE GEZA KORALEWSKI				ADDRESS (Street, city or town, state) MILLINGTON MD DATE SIGNED 5-23-59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March, 24, 1959		22c. NAME OF CEMETERY OR CREMATORY Riley's Neck, Cemetery		22d. LOCATION (City, town, or county) (State) Rural Millington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				ADDRESS Millington Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

07193

CERTIFICATE OF DEATH

212

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male / Female]</p>	
<p>3. AGE [Age of deceased]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. DATE OF DEATH [Date of death]</p>	
<p>7. TIME OF DEATH [Time of death]</p>		<p>8. PLACE OF DEATH [Place of death]</p>	
<p>9. CAUSE OF DEATH [Cause of death]</p>		<p>10. MANNER OF DEATH [Manner of death]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Signature of physician]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature of registrar]</p>	
<p>13. SIGNATURE OF WITNESS [Signature of witness]</p>		<p>14. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>15. SIGNATURE OF NEXT OF KIN [Signature of next of kin]</p>		<p>16. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>17. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>18. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>19. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>20. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>21. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>22. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>23. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>24. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>25. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>26. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>27. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>28. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>29. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>30. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>31. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>32. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>33. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>34. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>35. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>36. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>37. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>38. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>39. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>40. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>41. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>42. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>43. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>44. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>45. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>46. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>47. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>48. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>49. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>50. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>51. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>52. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>53. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>54. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>55. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>56. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>57. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>58. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>59. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>60. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>61. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>62. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>63. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>64. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>65. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>66. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>67. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>68. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>69. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>70. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>71. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>72. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>73. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>74. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>75. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>76. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>77. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>78. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>79. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>80. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>81. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>82. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>83. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>84. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>85. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>86. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>87. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>88. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>89. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>90. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>91. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>92. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>93. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>94. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>95. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>96. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>97. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>98. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>99. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>100. SIGNATURE OF DECEASED [Signature of deceased]</p>	

THE STATE OF MARYLAND
 DEPARTMENT OF HEALTH
 BIRTH - DEATH
 CERTIFICATE OF DEATH
 07193

3206

CERTIFICATE OF DEATH

Reg. Dist. No.

03200

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Md</u>				c. LENGTH OF STAY IN 1b <u>72 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne Hospital</u>				e. STREET ADDRESS <u>1407 Washington Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>HANNAH</u> Middle <u>Wetherall</u> Last <u>Bell</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Anthony Bell</u>				14. MOTHER'S MAIDEN NAME <u>Geraldine Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no. or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-5082</u>		17. INFORMANT Address <u>Miss Margaret Bell, Chestertown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs.</u> <u>2 years</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18</u> , 19 <u>50</u> , to <u>March 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 13</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. <u>3-13-59</u>							
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				<u>Chestertown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Farrlee Kent Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 18 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-1-19

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Room 306, Federal Bureau of Investigation Building, Washington, D.C.		6. COUNTY District of Columbia		7. CITY Washington		8. STATE District of Columbia	
9. OCCUPATION Attorney at Law		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. PLACE OF BURIAL Arlington National Cemetery, Arlington, Virginia	
13. SIGNATURE OF DECEASED (Not applicable for this case)		14. SIGNATURE OF WITNESS JAMES EARL RAY		15. SIGNATURE OF PHYSICIAN JAMES EARL RAY		16. SIGNATURE OF CORONER JAMES EARL RAY	
17. SIGNATURE OF REGISTRAR JAMES EARL RAY		18. SIGNATURE OF CLERK JAMES EARL RAY		19. SIGNATURE OF JURY JAMES EARL RAY		20. SIGNATURE OF JUDGE JAMES EARL RAY	

RECEIVED

10-1-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3214

CERTIFICATE OF DEATH

03201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Chestertown Adult life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X near - Chestertown, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home				d. STREET ADDRESS RFD # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle Clark Last Blackiston			4. DATE OF DEATH Month Mar. Day 9 Year 1959				
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1878		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laborer		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) St. Mary's Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME Laura Lawson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-24-1079		17. INFORMANT Mrs. Marion Clarkson Address Chestertown, Md. RFD # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.2 Angina Pectoris DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9 , 19 59 , to 3/9 , 19 59 , that I lost saw the deceased alive on 3/9 , 19 59 , and that death occurred at 5:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/10/59							
ACTUAL SIGNATURE E. Kester M.D.				PHYSICIAN'S NAME (Type) Eugene Kester Bock Hall, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/59		22c. NAME OF CEMETERY OR CREMATORY Asbury Cem. (Georgetown)		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR Mar 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED _____</p>		<p>AGE _____</p>		<p>SEX _____</p>	
<p>DATE OF DEATH _____</p>		<p>TIME OF DEATH _____</p>		<p>PLACE OF DEATH _____</p>	
<p>CAUSE OF DEATH _____</p>		<p>IMMEDIATE CAUSE _____</p>		<p>UNDERLYING CAUSE _____</p>	
<p>DATE OF BIRTH _____</p>		<p>PLACE OF BIRTH _____</p>		<p>EDUCATION _____</p>	
<p>OCCUPATION _____</p>		<p>RELIGION _____</p>		<p>PREVIOUS ILLNESS _____</p>	
<p>DATE OF DEATH _____</p>		<p>TIME OF DEATH _____</p>		<p>PLACE OF DEATH _____</p>	
<p>CAUSE OF DEATH _____</p>		<p>IMMEDIATE CAUSE _____</p>		<p>UNDERLYING CAUSE _____</p>	
<p>DATE OF BIRTH _____</p>		<p>PLACE OF BIRTH _____</p>		<p>EDUCATION _____</p>	
<p>OCCUPATION _____</p>		<p>RELIGION _____</p>		<p>PREVIOUS ILLNESS _____</p>	



CERTIFICATE OF DEATH

Reg. Dist. No.

03202

3207

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				d. STREET ADDRESS 525 High Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Chaires				4. DATE OF DEATH Month March Day 16 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1879		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Queen Annes		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Chaires				14. MOTHER'S MAIDEN NAME Sarah Cosden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-5401		17. INFORMANT Hospital Records Bhestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic & Hypertensive Cardiovascular disease with failure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/11/1959 to 3/16/1959 , that I last saw the deceased alive on 3/16/1959 , and that death occurred at 1:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 3/16/59	
PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/59		22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 59	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

CERTIFICATE OF DEATH

Reg. Dist. No.

03203

3208

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Worton (rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Edward Middle Dempsey Last Dempsey				4. DATE OF DEATH Month March Day 3 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1892	9. AGE (In years lost birthday) 66^{rs.}	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Dempsey				14. MOTHER'S MAIDEN NAME Rose Overton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-38-1557		17. INFORMANT Hospital Records, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 36 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Oct 11 , 19 55 , to March 3 , 19 59 that I last saw the deceased alive on 3/3 , 19 59 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown Md. DATE SIGNED 3/3/59 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-7-59	22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMTY	22d. LOCATION (City, town, or county) STILL POND, MD				
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy			ADDRESS STILL POND, MD	24a. REC'D BY REGISTRAR MAR 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		SEX MALE	
AGE 65		RACE WHITE	
DATE OF DEATH JAN 15 1900		TIME OF DEATH 10:30 AM	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH MAY 15 1834	
NAME JOHN J. JONES		NAME JOHN J. JONES	
OCCUPATION RETIRED		CAUSE OF DEATH OLD AGE	
PLACE OF DEATH HOME		SEX MALE	
AGE 65		RACE WHITE	
DATE OF DEATH JAN 15 1900		TIME OF DEATH 10:30 AM	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH MAY 15 1834	
NAME JOHN J. JONES		NAME JOHN J. JONES	
OCCUPATION RETIRED		CAUSE OF DEATH OLD AGE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03204

3215

Item 11 Film G240 3-18-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall - Rural</i>				c. LENGTH OF STAY IN 1b <i>X</i> <i>Tolchester</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>U S Army Nike Battery</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Fulbright</i> Last <i>Fulbright</i>				4. DATE OF DEATH Month <i>March</i> Day <i>1</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 13, 1935</i>		9. AGE (In years last birthday) <i>23</i> yrs.	IF UNDER 1 YEAR Months <i>23</i> Days <i>1</i>	IF UNDER 24 HRS. Hours <i>1</i> Min. <i>1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. ARMY</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Greenville, S. C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Walter D. Fulbright</i>			
14. MOTHER'S MAIDEN NAME <i>Violet Johnson</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> 1956-1959			
16. SOCIAL SECURITY NO. <i>260-50-7222</i>				17. INFORMANT <i>Cpt Fredrick Stevens</i> Address <i>Nike Base Tolchester Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MASSIVE FRACTURE BASE OF SKULL</i> 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>BASE OF SKULL</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Thrown from car which spilled & upset</i>			
20c. TIME OF INJURY Hour <i>2:00</i> p.m. <i>3/1</i> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>Rock Hall Kent Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Robert W. Farr</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>				22b. DATE THEREOF <i>3 March 59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Savannah, Georgia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L Lane Church Hill Md</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>Mar 1 1959</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		DATE <i>Mar 1 1959</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3216
CERTIFICATE OF DEATH

03205

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Rock Hall				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piney Neck Section				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edith Hudson Lemakis				4. DATE OF DEATH Month Day Year Mar. 10, 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1902	9. AGE (In years last birthday) yrs. 56	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - & Restaurant (Self-employed)				10b. KIND OF BUSINESS OR INDUSTRY (Self-employed)		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
13. FATHER'S NAME Charles Henry Hudson				14. MOTHER'S MAIDEN NAME Emma E. Crouch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-12-5773		17. INFORMANT Geprge Lemakis 1204 N. 63rd St. Baltimore - 6 Md.			
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Circumference DUE TO Circumference of Breast (c) Circumference of Breast							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Vessels							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Rock Hall, Md.		(County) (State)	
21. I certify that I attended the deceased from 250 7 , 1958, to March 10 , 1959, that I last saw the deceased alive on March 10 , 1959, and that death occurred at 8:30 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Norbert C. Nitsch				ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED Mar. 11, 1959			
PHYSICIAN'S NAME (Type) Norbert C. Nitsch							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) near - Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Mar 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hana			

CERTIFICATE OF DEATH

1911

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15, 1911*

5. Time of death: *10:30 AM*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Nature of disease: *Coronary Artery Disease*

9. Duration of disease: *Several years*

10. Occupation: *Engineer*

11. Usual place of abode: *123 Main St, Boston*

12. Name of physician: *Dr. J. H. Jones*

13. Name of undertaker: *John Doe*

14. Name of funeral home: *John Doe*

15. Name of cemetery: *Greenwood*

16. Name of lot: *123*

17. Name of interment: *John Doe*

18. Name of registrar: *John Doe*

19. Name of witness: *John Doe*

20. Name of witness: *John Doe*

21. Name of witness: *John Doe*

22. Name of witness: *John Doe*

23. Name of witness: *John Doe*

24. Name of witness: *John Doe*

25. Name of witness: *John Doe*

26. Name of witness: *John Doe*

27. Name of witness: *John Doe*

28. Name of witness: *John Doe*

29. Name of witness: *John Doe*

30. Name of witness: *John Doe*

31. Name of witness: *John Doe*

32. Name of witness: *John Doe*

33. Name of witness: *John Doe*

34. Name of witness: *John Doe*

35. Name of witness: *John Doe*

36. Name of witness: *John Doe*

37. Name of witness: *John Doe*

38. Name of witness: *John Doe*

39. Name of witness: *John Doe*

40. Name of witness: *John Doe*

41. Name of witness: *John Doe*

42. Name of witness: *John Doe*

43. Name of witness: *John Doe*

44. Name of witness: *John Doe*

45. Name of witness: *John Doe*

46. Name of witness: *John Doe*

47. Name of witness: *John Doe*

48. Name of witness: *John Doe*

49. Name of witness: *John Doe*

50. Name of witness: *John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03206

3217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Rock Hall		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche First Middle Last Page		4. DATE OF DEATH Mar. 1, 1959 Day Month Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY New York State	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Donnelly		14. MOTHER'S MAIDEN NAME Elizabeth Beamn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Thos N. Page	
17. INFORMANT Rock Hall, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 17, 1959 , to March 1, 1959 , that I last saw the deceased alive on Feb 27, 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 3/2/59			
ACTUAL SIGNATURE Wm. M. Gatewood M.D.		PHYSICIAN'S NAME (Type) Wm. M. Gatewood	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		22d. LOCATION (City, town, or county) (State) near - Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTY OF EXAMINATION		STATE OF EXAMINATION	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF NURSE		NAME OF MIDWIFE		NAME OF OTHER ATTENDING	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF NURSE		SIGNATURE OF MIDWIFE		SIGNATURE OF OTHER ATTENDING	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTY OF SIGNATURE		STATE OF SIGNATURE	
NAME OF REGISTRAR		NAME OF CLERK		NAME OF ASSISTANT CLERK		NAME OF DEPUTY REGISTRAR		NAME OF DEPUTY CLERK	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF ASSISTANT CLERK		SIGNATURE OF DEPUTY REGISTRAR		SIGNATURE OF DEPUTY CLERK	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTY OF SIGNATURE		STATE OF SIGNATURE	

RECEIVED
JAN 10 1910
BALTIMORE

CERTIFICATE OF DEATH

03207

Reg. Dist. No.

3213

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>EMMA</u> Middle <u>PENN</u> Last		4. DATE OF DEATH <u>March</u> Month <u>22</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 15-1879</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL COLEMAN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA MULLICA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Ethel Peterman</u> Address <u>Rock Hall Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>794X</u> DUE TO <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>3</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/19</u> , 19 <u>59</u> , to <u>3/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Kester</u>		ADDRESS (Street, city or town, state) <u>Rock Hall</u> DATE SIGNED <u>3/24/59</u>	
PHYSICIAN'S NAME (Type) <u>E. KESTER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR. 25</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Daniel</u> ADDRESS <u>Church Hill Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3219 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton(rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Betterton(rural)	
c. LENGTH OF STAY IN lb Life		d. STREET ADDRESS X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Micheal Middle Lee Last Plugge		4. DATE OF DEATH Month March Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 5 1958
9. AGE (in years last birthday) yrs. 5 Months 8 Days 8		10. IF UNDER 1 YEAR Months 5 Days 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Franklin Plugge		14. MOTHER'S MAIDEN NAME Betty Olive Sparks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Betty Plugge(mother)		Address Betterton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown but probably of natural causes 501X DUE TO Tracheobronchitis & Bronchopneumonia Conditions, if any, which gave rise to immediate cause (b) Baby was put in its crib apparently well about 9 PM (c) 3/12/59. Was found dead in its crib at 5:00 AM today.		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Autopsy results not available at time of filling out this certificate.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 13, 1959	
EXAMINER'S NAME (Type) ROBERT W. FARR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1959	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS CHESTERTOWN, MD	
24a. REC'D BY REGISTRAR MAR 16 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2072224XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3220 CERTIFICATE OF DEATH

03209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH EARL PRICE				4. DATE OF DEATH Month March Day 12 Year 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Insurance Salesman				10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Price				14. MOTHER'S MAIDEN NAME Rachel UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-6203		17. INFORMANT Address Mrs. Edith Price, Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) meningitis DUE TO (c) Influenza						INTERVAL BETWEEN ONSET AND DEATH 2 day 2 weeks 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 27, 1959 , to March 12, 1959 , that I last saw the deceased alive on March 12, 1959 , and that death occurred at 10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Koralewski				ADDRESS (Street, city or town, state) MILLINGTON, MD		DATE SIGNED 3.15.59	
PHYSICIAN'S NAME (Type) GEORGE KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Millington Col. Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloway				ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '59	
				24b. REGISTRAR'S SIGNATURE Clarence S. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

3209

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 2 MOS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 CHESTERTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 72 KENT & QUEEN ANNE'S HOSP.				d. STREET ADDRESS 210 WASHINGTON AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARIAN C. PRICE				4. DATE OF DEATH Month Day Year MAR 19 1957			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 2, 1902		9. AGE (In years lost birthday) yrs. 56	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANK TELLER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME S. G. CALDWELL				14. MOTHER'S MAIDEN NAME EMMA STRADLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-4013		17. INFORMANT HOSPITAL CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 METASTATIC CARCINOMA OF LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PRIMARY CARCINOMA OF COLON DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR 1958 , to MAR 19 1957 , that I last saw the deceased alive on MAR 17 1957 , and that death occurred at 6:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESTERTOWN, Md. DATE SIGNED 3-19-57							
ACTUAL SIGNATURE A. T. Keefe, Jr. M.D.				PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 22/59		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams <i>Marvin V. Williams</i>				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR MAR 24 59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3210

CERTIFICATE OF DEATH

03211

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Queen Anne's Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL RASH</u>		4. DATE OF DEATH Month Day Year <u>MARCH 27 19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/59</u>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LEWIS WILLIAM RASH</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR ELIZABETH CECIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atalectasis</u> <u>762.5</u> DUE TO <u>Prematurity (estimated duration of pregnancy 28 weeks)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>28 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/27</u> , 19 <u>59</u> to <u>3/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>59</u> , and that death occurred at <u>9:15A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3/27/59</u>			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert W. Farr, M. D., 305 Washington Ave., Chestertown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 28 1959</u>	<u>Mullington Cemetery</u>	<u>Mullington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Dillman</u> ADDRESS <u>Mullington Md.</u>		24. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072236XVO

18 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) LEONARD W. ROBINSON				4. DATE OF DEATH March 19, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 31, 1897		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Driver		10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Robinson				14. MOTHER'S MAIDEN NAME Laura Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-32-0614		17. INFORMANT Marvin Robinson, Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. myocardial insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Posterior myocardial infarct DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. indigestion							
INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) Millington				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Feb 7, 1949 , to Mar 19, 1959 , that I last saw the deceased alive on Mar 19, 1959 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Hamilton				DATE SIGNED 3/2, 1959			
PHYSICIAN'S NAME (Type) H. H. HAMILTON				ADDRESS (Street, city or town, state) Millington Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March, 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03213

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

3222

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chestertown		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home RFD # 2		e. STREET ADDRESS RFD # 2	
3. NAME OF DECEASED (Type or print) Fred First Skipper Middle lost		4. DATE OF DEATH Mar. 30, 1959 Year 19	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May. 8, 1881
9. AGE (in years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77	IF UNDER 24 HRS. Hours 77 Min. 77
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Junk dealer		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Dont know		14. MOTHER'S MAIDEN NAME Dont know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Martha Skipper Address Chestertown, Md. RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 835X DUE TO Wheel of car falling or running onto throat and neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Car fell or ran off jack and onto deceased's throat & neck. (b) When found, the motor of the car was running & the car was in reverse gear. (c) car was in reverse gear. </p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH none</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18)	
20c. TIME OF INJURY 2:30 p.m. 3/30 59 Month, Day, Year		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Town home		20f. (City or town) (County) (State) Chestertown (rural) Kent Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Apr. 1, 1959	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Georgetown Cem.	22d. LOCATION (City, town, or county) (State) near Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR APR 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 37 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 High St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 409 High St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sue Middle Thompson Last Thompson		4. DATE OF DEATH Mar. 10 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 10 Days 10 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Christhlf		14. MOTHER'S MAIDEN NAME Laura unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Raphael Copper		18. ADDRESS Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary atherosclerosis - many years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) short time			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1 , 19 59 , to Mar. 10 , 19 59 , that I last saw the deceased alive on Mar. 9 , 19 59 , and that death occurred at 1 A. -M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr		DATE SIGNED 3/12/59	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Mar. 12, 1959	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR MAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

3212

CERTIFICATE OF DEATH

03215

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 da.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Barry Middle Neilson Last Townsend				4. DATE OF DEATH Month March Day 10 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1959		9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Edward Townsend				14. MOTHER'S MAIDEN NAME Virginia Mae Merchant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Address Hospital Records Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atalectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Prematurity (estimated duration of pregnancy 30 weeks) DUE TO (c) 30 weeks						INTERVAL BETWEEN ONSET AND DEATH 16 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 9, 1959 to Mar. 10, 1959 , that I last saw the deceased alive on Mar. 10, 1959 , and that death occurred at 9:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 3/11/59 ACTUAL SIGNATURE Robert W. Farr, M. D. M.D. Chestertown, Md. PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11 / 59		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				24a. REC'D BY REGISTRAR MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03216

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Carroll Willson				4. DATE OF DEATH Month Day Year Mar. 3, 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 9, 1904	
9. AGE (In years last birthday) yrs 54		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Bus Driver				10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME A. Carroll Willson				14. MOTHER'S MAIDEN NAME Gertrude Hadaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 215-20-1539		17. INFORMANT Address J. Ernest Willson - Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH 10 min.			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on March 3, 1959 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rock Hall, Md. Mar. 3, 1959							
ACTUAL SIGNATURE Wm. M. Gatewood M.D.							
PHYSICIAN'S NAME (Type) Wm. M. Gatewood							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/59		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) near - Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wallis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE MAR 6 '59	
				24b. REGISTRAR'S SIGNATURE Christina L. House			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home of Son		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
3. NAME OF DECEASED (Type or print) First Hester Middle Ann Last Wiltbank		4. DATE OF DEATH Mar. 17, 1959 Month Mar. Day 17 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Cecil Co. Maryland	
11. BIRTHPLACE (State or foreign country) W.S.A.		12. CITIZEN OF WHAT COUNTRY? W.S.A.	
13. FATHER'S NAME Joshua Register		14. MOTHER'S MAIDEN NAME unk Hessey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Hilda Bennett		Address 411 High St. Chestertown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency with 420.1 DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH one hour 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17 , 19 59 , to 3/17 , 19 59 , that I last saw the deceased alive on 3/17 , 19 59 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 3/18/59			
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/59	
22c. NAME OF CEMETERY OR CREMATORY Galena Cem.		22d. LOCATION (City, town, or county) (State) Galena Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of funeral home		14. Name of undertaker		15. Name of cemetery		16. Name of church	
17. Name of family		18. Name of next of kin		19. Name of executor		20. Name of administrator	
21. Name of guardian		22. Name of trustee		23. Name of agent		24. Name of attorney	
25. Name of executor		26. Name of administrator		27. Name of guardian		28. Name of trustee	
29. Name of agent		30. Name of attorney		31. Name of executor		32. Name of administrator	
33. Name of guardian		34. Name of trustee		35. Name of agent		36. Name of attorney	
37. Name of executor		38. Name of administrator		39. Name of guardian		40. Name of trustee	
41. Name of agent		42. Name of attorney		43. Name of executor		44. Name of administrator	
45. Name of guardian		46. Name of trustee		47. Name of agent		48. Name of attorney	
49. Name of executor		50. Name of administrator		51. Name of guardian		52. Name of trustee	
53. Name of agent		54. Name of attorney		55. Name of executor		56. Name of administrator	
57. Name of guardian		58. Name of trustee		59. Name of agent		60. Name of attorney	
61. Name of executor		62. Name of administrator		63. Name of guardian		64. Name of trustee	
65. Name of agent		66. Name of attorney		67. Name of executor		68. Name of administrator	
69. Name of guardian		70. Name of trustee		71. Name of agent		72. Name of attorney	
73. Name of executor		74. Name of administrator		75. Name of guardian		76. Name of trustee	
77. Name of agent		78. Name of attorney		79. Name of executor		80. Name of administrator	
81. Name of guardian		82. Name of trustee		83. Name of agent		84. Name of attorney	
85. Name of executor		86. Name of administrator		87. Name of guardian		88. Name of trustee	
89. Name of agent		90. Name of attorney		91. Name of executor		92. Name of administrator	
93. Name of guardian		94. Name of trustee		95. Name of agent		96. Name of attorney	
97. Name of executor		98. Name of administrator		99. Name of guardian		100. Name of trustee	